

U.S. ARMY-BAYLOR UNIVERSITY

**MANAGEMENT OF MANAGED CARE: WHAT DOES IT TAKE?**

A GRADUATE MANAGEMENT PROJECT  
SUBMITTED TO THE FACULTY  
OF U.S. ARMY-BAYLOR UNIVERSITY IN CANDIDACY FOR  
A MASTERS DEGREE IN HEALTH CARE ADMINISTRATION

BY

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## **EXECUTIVE SUMMARY**

The Military Health Services System (MHSS) has not been immune to the many problems plaguing health care delivery in the United States. Escalating health care costs and uneven access to care has led to the adoption of the Department of Defense's managed health care program known as TRICARE. The success of the TRICARE Program cannot be overstated as it allows the MHSS to meet its dual missions simultaneously. However, as this is a relatively new program within the MHSS, a consensus on the key job functions to be performed by medical department officers serving in an administrative managed care positions still needs to be reached, and the skills, knowledge, and abilities (SKAs) for successful performance clearly identified. During two rounds of the Delphi technique, the Executive Steering Committees from 27 CONUS Navy Military Treatment Facilities were first asked to identify these job tasks, and then rate 185 related SKAs on their relative importance. A total of nine key job functions were identified to include 225 unique job tasks along with the prerequisite SKAs that reflect the need for managed care administrators to possess strong interpersonal skills.

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## **CHAPTER 1**

### **INTRODUCTION**

TRICARE, the Department of Defense's (DoD) new managed care program, was borne out of the necessity to contain escalating health care costs, remove uneven barriers to access, reduce duplication of services, and provide a more uniform health benefits package to eligible military beneficiaries. Several unique features under the TRICARE program include the Lead Agent Concept, the triple option plan, and the fixed price at-risk TRICARE managed care support contracts and the transition to a capitation based budgeting system (Lamar 1994).

In a move to consolidate resources and foster joint service cooperation, the country has been divided into 12 regions by DoD. Tri-service Lead Agents have been designated for each region. The Lead Agents are tasked with coordinating the cost-effective delivery of quality health care between the three medical departments and with civilian agencies through established contractual relationships. Table 1 taken directly from a 1995 U.S. General Accounting Office report provides a breakdown by region with the established time frames for the implementation of TRICARE (GAO/T-HEHS-95-117). Also, in support of TRICARE, DoD has already shifted Military Treatment Facilities (MTFs) away from the traditional workload incentives to justify resources to that of capitation budgeting accompanied with a stronger focus on utilization management to curb costs (GAO/HEHS-95-104).

**TABLE 1**  
**TRICARE REGIONS**

Region	Lead Agent	States in Region	Implementation Date
1.	National Capital (Bethesda, Walter Reed, Malcolm Grow Medical Centers)	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Northern Virginia	May 1997
2.	Portsmouth Naval Hospital	North Carolina, Southern Virginia	May 1997
3.	Eisenhower Army Medical Center	Georgia, South Carolina, parts of Florida	May 1996
4.	Keesler Air Force Medical Center	Alabama, Tennessee, parts of Florida and Louisiana	May 1996
5.	Wright-Patterson Air Force Medical Center	Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, Wisconsin	May 1997
6.	Wilford Hall Air Force Medical Center	Arkansas, Oklahoma, parts of Louisiana and Texas	November 1995
7.	William Beaumont Army Medical Center	Arizona, Nevada, New Mexico, parts of Texas	November 1996
8.	Fitzsimons Army Medical Center**	Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, parts of Idaho	November 1996
9.	San Diego Naval Hospital	Southern California	October 1995
10.	David Grant Air Force Medical Center	Northern California	October 1995
11.	Madigan Army Medical Center	Oregon, Washington, parts of Idaho	March 1995
12.	Tripler Army Medical Center	Hawaii	October 1995

Note: \*\*Recommended for closure (GAO/HEHS-95-117)

Under the managed care support contracts, the Triple Option plan provides beneficiaries with a choice of health plans. TRICARE Standard or the fee for service options allows for a great deal of flexibility and choice in selecting a physician, but the individuals must bear considerable costs for this freedom. TRICARE Extra is very similar except the members' out of pocket costs are reduced if they choose to see a physician from a network of Preferred Providers established by the contractor. The managed care component known as TRICARE Prime requires beneficiaries to enroll and elect a primary care physician who will provide their health care from an integrated network of military or civilian providers. The cost sharing provisions under TRICARE Prime are relatively inexpensive for both inpatient and outpatient care compared to the other two options. However, Medicare eligible beneficiaries are not currently eligible to participate in TRICARE PRIME (GAO/HEHS-95-104).

The TRICARE program grew out of several managed care demonstration projects conducted at various DoD sites throughout the nation during the late 1980s because of the high rate of growth in CHAMPUS expenditures. Under CHAMPUS, medical benefits are provided by public law to eligible beneficiaries comprising the seven uniformed services. The CHAMPUS Reform Initiative (CRI), Catchment Area Management Projects, Contracted Provider Arrangement in Norfolk, Virginia and the Southeast Region's Preferred Provider Organizations were the key programs initiated by DoD. These demonstration projects used various principles of managed care to include the use of primary care providers as gate-keepers, an enrollment system and patient financial incentives coupled with a strong emphasis on utilization management. The CRI project conducted in Hawaii and California helped lay the foundation for the TRICARE program as it was based on a contractual relationship with Foundation Health to provide managed

health care services to eligible DoD beneficiaries. A triple option plan based on various cost-sharing provisions was also introduced as part of CRI, which is similar to the options now provided under TRICARE (Kongstvedt 1993).

The first TRICARE managed care support contract awarded to Foundation Health Services, Incorporated became fully operational in March 1995 in Region 11 followed shortly thereafter by Region 6, and the enrollment in the managed care option has exceeded initial expectations for both regions. Foundation Health is also the contractor for Regions 9, 10 and 12. Humana Military Health Services was awarded the contract for Regions 3 and 4. Contract awards for Regions 1, 2, and 5 are currently being selected and will be awarded in the near future. Although, the initial goal was to have all of the TRICARE support contracts awarded and have a fully operational, nationwide military managed health care system by September of 1996, Congress granted a one year extension (Office of ASD 1996A). The contract for Regions 7 and 8 was recently awarded to Tri-West.

#### Conditions Which Prompted the Study

As TRICARE is a relatively new program in the Military Health Services System (MHSS), a variety of functions and tasks relating to managed care are now emerging in conjunction with the life cycle of the managed care support contracts. This fact is readily apparent by the responses received from 20 CONUS, Navy MTFs to a telephone inquiry conducted in March 1996 by Lieutenant Commander C. Britton of the Bureau of Medicine and Surgery's (BUMED) Health Care Operations and Policy Division. According to this telephone survey, the type of functions falling under the umbrella of managed care include the following: marketing, liaison with Lead

Agent Offices and TRICARE contractors, development of business plans, strategic planning, initiating resource sharing agreements, conducting utilization management and negotiating with civilian contractors. However, the breath and scope of the functions and tasks being conducted is fragmented and inconsistent from site to site and the number of individuals dedicated solely to managed care often varies between similar sized MTFs (Britton 1996).

This may be attributed to the fact that no formal billet structure has been identified at the local MTFs by Navy Medicine. Commands have found it necessary to designate one or more staff members from within their current officer manpower allowance to perform these critical functions or assign them as additional collateral duties. Therefore, the ranks and corps of the officers assigned are dependent on the current staffing and needs of the MTFs concerned. Although a few commands have reflected "in-house billet" changes in response to the need to establish managed care positions, the billet file at Navy Medicine has not kept pace due to the considerable amount of time it takes to make these changes. Managed care billets have been identified at several of the regional Lead Agent Offices; the Naval Healthcare Support Offices at San Diego, California, Norfolk, Virginia and Jacksonville, Florida; the Bureau of Medicine and Surgery; Office of CHAMPUS; and within the Assistant Secretary of Defense for Health Affairs (Britton 1996).

As the TRICARE contracts evolve into the post-contract award phase, there is a great deal of interest by Navy Medicine to identify the key job functions to be performed under managed care especially at the local MTF level. Currently, no formal consensus has been reached, nor have the skills, knowledge and abilities (SKAs) required by medical department officers been clearly identified. Although the Navy has developed a new additional qualification designator (AQD) to assist detailers in making personnel assignments to managed care positions, it is

expressed in basic terms regarding the type and level of experience and education required with no specific SKAs being stated. The Managed Care Officer AQD 6SG will be awarded only to health care administrators of the Medical Service Corps (MSC) who have a masters degree in health care administration and at least one year experience in a managed care officer position, which must be supported by their Commanding Officer's endorsement (Medical Service Corps 1996). As of October 1996, only 27 MSC officers possess this AQD. The following table is a breakdown by rank and speciality:

**TABLE 2**  
**MSC AQD ASSIGNMENTS**

<b>AQDs BY PAY GRADE</b>		<b>AQDs BY SPECIALTY</b>	
Captain (0-6)	3	Financial Management	2
Commander (0-5)	4	Manpower	1
Lieutenant Commander (04)	10	Health Care Administrators	17
Lieutenant (03)	8	Patient Administration	5
Lieutenant Junior Grade (02)	2	Contingency Officers	1
		Material Management	1

(Jewett 1996)

#### Problem Statement

With the many challenges facing the MHSS, many outside parties are looking for ways to restructure the MHSS to further reduce costs. In a 1995 report by the Congressional Budget Office, it was recommended that the majority of care currently provided in MTFs be outsourced to the civilian sector through the Federal Employees Health Benefits Program (Office of ASD

1995). Therefore, success of the TRICARE program is essential to preserving the MHSS. The added flexibility that TRICARE provides through its civilian partnerships and interservice collaboration allows the MHSS to meet its readiness missions and conduct the necessary training without impeding on the MHSS' ability to deliver care to all eligible beneficiaries. In other words, TRICARE allows the MHSS to successfully meet its dual mission simultaneously. This new capability is accomplished in part by the support agreements with civilian agencies that provide for a network of providers to supplement the staff of the MHSS and by the necessity for the three services to share resources (Office of ASD 1996B).

However, without a formal consensus and understanding of the job functions to be performed under TRICARE at the local MTF level, the success of the TRICARE program may be jeopardized. Furthermore, the SKAs required of health care professionals to successfully perform the administrative tasks associated with the TRICARE contracts have not been adequately identified because the program is still evolving within the MHSS. Until an adequate baseline is established, the potential for serious consequences to arise in the future will remain a threat.

#### Literature Review

Current textbooks devoted to the subject of managed care expound on the major principles of managed care that include controlling costs, enhancing quality, and improving access to health care. Utilization management, information management systems, quality control mechanisms, pricing strategies, benefit design, contract negotiations, marketing, capitation, finance and budget controls, and the development of provider networks are all key components of

managed care (Boland 1993 and Kongstvedt 1995). However, very little research has been focused on the skills necessary for health care administrators to function in a managed care position. The literature has been dedicated to the changing roles of hospital Chief Executive Officers (CEOs) and mid-level managers throughout the past two decades as they adapt to keep pace with growing concern over escalating health care costs and increased competition generated by the growth in managed care plans. The educational requirements necessary to prepare CEOs and mid-level managers to function in this turbulent era of health care have also been widely explored.

In 1955, Robert Katz, Assistant Professor of Business Administration at Dartmouth College, discussed the three basic skills he believed were common to effective administrators, which included technical, human, and conceptual. Technical skills relate to the high level of proficiency exhibited in a particular job field. Human skills define an administrator's ability to effectively communicate, understand other individuals' points of view, and work well with others. Conceptual skills refer to an administrator's ability to be visionary and able to understand the "big picture" of the organization (Katz 1974). As the literature review will show, these basic skills uncovered over four decades ago still have credence today for health care executives.

In a study conducted in the mid-80s, supervisors were asked to rank their employees, recent graduates of Arizona State University's graduate program in health services administration, on several key factors and skills. The results of the study indicate that graduates are not well prepared in the areas of quantitative analysis, decision-making ability and interpersonal skills (Boissoneau and Kirkman-Liff 1984). In another study, the curriculum of baccalaureate programs in health care administration was assessed based on the knowledge and skills deemed important



now and in the future by practitioners for successful job performance. Past results (1981), coupled with present (1987) and future ratings (1995) were compared and analyzed. A total of 34 knowledge and skills areas were ranked. Financial management, interpersonal skills and knowledge of the health care sector were consistently rated in the top five for each period. Communication skills and knowledge of information systems were deemed critical for success in the future. Many respondents in the survey also felt that a Masters Degree in Health Care Administration and additional work experience was required (Reagan 1990).

In a needs assessment survey, senior managers, department heads and supervisors of hospitals were asked to identify areas where mid-level managers require additional training and development. All three groups agreed on the need of mid-level managers to improve verbal communication, enhance productivity and control costs, strengthen problem solving skills, and understand Diagnosis-Related Groups and their effect on hospital operations (Henderson et al. 1985). In a recent study, mid-level managers in acute hospitals located throughout New England were asked to rank by level of importance designated skills and their level of competence in performing them. Not surprisingly, communications, financial control, interpersonal relations, and strategic assessment skills were all rated as important functions, but the group believed they needed to improve their competency in these specific areas. Less than half of the 196 respondents held a masters degree (Roemer 1996).

Paula Eubanks' article "The New Hospital CEO: Many Paths to the Top" highlights the skills required of hospital CEOs to succeed in this new decade of managed care and continued change. Financial skills coupled with strong interpersonal relationship skills will be critical. The CEO position will be open for all viable contenders to include physicians, nurses, and large group

practice managers to name a few. Additional skills necessary now and in the future include strategy formulation and planning, negotiations and consensus building, human resources development, community relations, marketing, and information technology. CEOs need to be visionary, possess the propensity to take risk, make decisions, and develop strong working relations with physicians (Eubanks 1990). The top responses to a survey of 324 CEOs concerning the future skills required of CEOs closely parallel those reported by Eubanks (Sieverking and Wood 1992). In addition to those skills previously identified, Zuckerman highlights the growing importance of the CEOs role in governance and need to manage quality (Zuckerman 1989).

In a Delphi study, 50 hospitals CEOs and fellows of the American College and Healthcare Executives were asked their opinions on the top issues facing healthcare administrators through the year 2000 and the SKAs required to successfully deal with them. The key issues identified in order of importance were cost/finance, leadership, professional staff interactions, health care delivery concepts, accessibility, ethics, quality/risk management, technology, and marketing. Although cost/finance issues were rated as the number one challenge, the majority of the top rated SKAs identified by the group emphasized interpersonal skills to include communication and listening, problem solving, human relations, and understanding physician motives and needs (Hudak et al. 1993).

The studies discussed contain a central theme that although solid financial and quantitative skills are still important in the field of health care, the development of interpersonal skills and the need for practical experience will be essential for future leaders. The ability to negotiate, resolve conflicts, and develop relationships cannot be overemphasized as market pressures intensify

(Goldsmith 1985). This sentiment reflects the changes occurring in the academic environment. In essence, programs in health care administration are coming full circle. Fundamental changes to the curriculum occurred in the 1970s as professors with work experience in hospitals were replaced by academic based professors who shifted the concentration of the programs to research and theory with a strong emphasis on business skills, which continued through the 1980s. Today, key changes are occurring as academic programs attempt to balance theory with practical experience by lengthening the programs, changing the curriculum, and reinstating the one year residency requirement (Greene 1990). However, the debate continues to whether a masters in business (MBA) or health care administration (MHA) is more appropriate in today's highly competitive and turbulent health care environment (Greene 1990; Goldsmith 1985; and Earle and Pfannkuche 1991).

Graduates of hospital administration programs in the 1970s have experienced the rapid changes in health care delivery first hand resulting in a shift in demand from management to financial skills in the 1980s as result of increasing government regulations and cost containment concerns. With so many other factors influencing financial decisions, financial skills alone did not guarantee success so the focus one again shifted to results-oriented management. The graduates could also no longer be guaranteed a position as a Hospital CEO even if the traditional career paths were followed. Many of the graduates made the decision to move on to other fields or enter other health care related jobs outside the hospital industry. For those now working in managed care, the ability to learn to communicate successfully with physicians about methods to contain costs was the factor cited in securing these new positions (Eubanks 1991). Two large managed care organizations, Kaiser Permanente and Humana, even provide on-the-job training and

courses for their health care executives on managed care to supplement their masters degrees by combining theory with practice (Lutz 1990).

Future career opportunities predicted by a group of health care executive search and management consultants include a diverse array of ten job positions often requiring a new mix of skills and proven track records. The job titles include Group Practice Administrator, Health Data Analyst Manager, and President, Chief Executive Officer, Integrated Health System. The majority of these positions may either require MBA or MHA, Doctorate (Ph.D.) or Medical Degree (M.D.) accompanied with a myriad of skills and experience to include the propensity to work well with physicians, analytical ability, strong leadership skills and ethics, and experience in the corporate environment (Hot Careers in Health Care 1993).

In her article "Is Hospital Administration Dead?" Sharyn Bills solicits the opinions from senior health care executives and executive search consultants on the viability of health care executives with hospital backgrounds to remain competitive in the marketplace that is rapidly being dominated by integrated systems of care. Although the consensus is that hospital administration is not dead, changes are inevitable and the keys to continued success will be the ability to remain flexible and adaptable. A participative management style, strong communication and negotiation skills, and the ability measure outcomes will be essential prerequisites in the future for health care executives who desire to make the transition from an acute care hospital to various group settings falling under the umbrella of managed care. Political savvy in dealing with a variety of groups will also be important notes Thomas Chapman, FACHE, the CEO of University Hospital, George Washington University Hospital, Washington, DC (Bills 1994).

Many of the skills previously identified for CEOs of hospitals mirror those required for the new breed of network executives emerging as result of the growing trend to integrate health care systems to include being a strategic thinker, problem solver, coalition builder, and conflict manager (Sherer 1993). Managed care also requires administrators to be skilled in marketing, claims, risk management, and membership services with the ability to build a strong rapport with physicians (Eikevik 1994). The ability to conduct win-win negotiations utilizing an interest-based approach coupled with imagination will be paramount as competition intensifies in the current health care industry, and mergers become the norm (Laubach 1997).

In a recent article exploring the skills required of managed care executives, once again, many of the skills previously predicted as requirements for future health care executives are repeated. Specifically, the need have a strong understanding of clinical processes and the tools to measure variation in clinical practices and outcomes will be essential to modifying physicians' practice patterns. Today, sound financial skills become even more critical as managed care executives need to managed financial risk based on the health risk of their enrolled population. The roles of leaders in managed care organizations will be extremely different as they will need to move away from the top-down management approach traditionally employed in hospitals to managing and motivating teams. Executives who have the ability to empower others, negotiate, and solve problems creatively with a sense of vision will be highly valued (Carol 1997).

Russell C. Coile, Jr. predicts that in the 21st century health care executives will find themselves working in management teams to manage risk under a predominately capitated system of managed care. Integration of key components such as physicians and information management systems will be critical to meeting the challenge of providing cost effective and quality health care

across a continuum. The successful management of patients will also require a stronger focus on clinical processes leading Coile to speculate that physicians and nurse executives with administration and clinical background will be highly sought by health care organizations to become members of the management teams. He advocates the need to promote clinical managers to higher levels in the organization and increase the representation of physicians on governing boards and committees. As Coile points out the future for traditional health care executives "need not be bleak." Nonclinical administrators with proven leadership and managed care negotiation skills coupled with the ability to work well with others will find opportunities in the new millennium of integrated delivery networks (Coile 1996).

As previously highlighted, MHSS has not been immune to many problems plaguing health care delivery in this country. In response to the growing concern that MTF leaders may be ill prepared to face these challenges, Congress mandated that DoD develop a set of required administrative competencies and skills for future commanders (Deputy Secretary of Defense 1991). A tri-service task force was convened by the Secretary of Defense for Health Affairs, and over 30 sets of skills and knowledge requirements were identified in addition those unique to the military. The areas of competence upon which the skills were developed included clinical and general management, health resources, ethics, and health law and policy along with military specific competencies such as medical readiness (Department of Defense 1992).

The Army Medical Department Center and School (AMEDDC&S) in 1993 was formally tasked with developing a joint service training program to include all of the competencies required to successfully command a MTF. This tasking was in response to the results of a DoD Inspector General's report that highlighted the fact that no current military or civilian education and training

plans included all 40 competencies, nor did a current system exist to screen future MTF commanders on their ability to perform them. From this assignment, the Joint Medical Executive Skills Development Working Group was created in 1994 by the AMEDDC&S (Executive Skills Training Report to the Congress July 1996).

As a result of the Working Group's research efforts, six additional core competencies have been identified to include leadership, military mission, personal and organizational ethics, public and media relations, and public speaking. Additionally, behaviors to assess the ability of future leaders to perform these 40 competencies have been developed along with an Executive Skills Training Program core curriculum. For example, under the core competency of leadership, a commander must display the following: commitment, courage, ethical behavior, and integrity. Curriculums are being revised to ensure all 40 competencies are being taught to include the curriculum for the U.S. Army-Baylor Program in Health Care Administration, and catalogs listing training sources to gain the required competencies have also been generated (Executive Skills Training Report of the Congress 1996 and Executive Skills Training Core Curriculum July 1996).

To add to this body of work, a Delphi study was undertaken by Hudak, Brooke, and Finstuen. A total of 37 Army MTFs Commanders and Deputy Commanders for Administration were asked to identify the key issues challenging their facilities now through the turn of the century and the SKAs required of MTF leaders to effectively deal with them. The main issues identified in descending order of priority based on frequency of response include cost-finance, health care delivery, accessibility, quality and risk management, technology, professional staff, leadership, marketing, and ethics. The top rated SKAs were the same for both groups except in the areas of professional staff and leadership. Technical SKAs were identified for the areas of

cost-finance, quality and risk management, and technology to include the need to understand managed care initiatives and contracts, cost benefit analysis and quantitative techniques, utilization management, and information management skills. Interpersonal SKAs were predominant for the remaining areas to include listening skills, communication, conflict management, team building, political and negotiation skills (Hudak, Brooke, and Finstuen 1994). The results are strikingly similar to those conducted in the civilian sector as a vast array of skills will be necessary for the future military health care leader to include a balanced mix of both technical and interpersonal skills.

With the constant pressures on Navy Medicine to justify MSC billets and operate within a shrinking budget, Lieutenant Commander Butler of BUMED's Hospital and Clinic Operations Branch advocates a major change from the corps' traditional career pathways that focus on job specialization. She believes generalists who are able to serve as group practice managers in ambulatory care centers will be required in the near future along with a new set of skills and knowledge to enable a smooth transition under managed care. Their roles as practice managers will be to ensure the delivery of quality, cost efficient care within their centers or individual clinics requiring a broad working knowledge in the areas of finance, human resources, marketing, information systems, and managed care (Butler 1997).

Health care administrators must acquire the competencies to be planners, negotiators, facilitators, mediators and sound decision makers. Analytical skills coupled with knowledge of information sources will also be extremely important as well as communication skills, both written and verbal. They must have a general knowledge of the current trends in health care delivery such as vertical and horizontal integration, disease management, and the continuum of care.



Benchmarking tools are a must for all practice managers to be able to provide comparable data to physicians to modify their practice patterns. Notwithstanding, the health care administrators as Naval Officers must also remain current in areas relating to military medical readiness (Butler 1997).

### Purpose

In summary, the body of research concerning the challenges facing health care administrators and the skills required in the future has centered predominately on CEOs of civilian hospitals. The military has taken the initial step to identify core competencies and skills required of MTF leaders, and additional research has been conducted in this area. However, research specifically relating to the skills and competencies required to succeed in managed care positions in the MHSS is lagging along with the job functions to be performed now and in the future as the TRICARE contracts mature. Therefore, the purpose of this Graduate Management Project is to identify the key administrative managed care job functions that will be necessary following post-contract award of the TRICARE managed care support contracts, and the SKAs required of medical department officers to successfully complete them.

## **CHAPTER 2**

### **METHODS AND PROCEDURES**

The Delphi technique was the research method used in this study. This technique involves a series of iterations; whereby expert respondents provide their individual opinions on a particular subject and through feedback and subsequent iterations, group consensus is achieved (Loughlin and Moore 1979). Developed at the Rand Corporation by Dr. Olaf Helmer, a mathematician-philosopher and founder of the Institute for the Future, the Delphi technique was initially used as a forecasting tool. The three main components that distinguish it from other group decision making models are anonymous response, iterations and controlled feedback, and statistical group response. During the sixties, a series of experiments were conducted by Norman Dalkey of the Rand Corporation to assess the various components. The results were favorable when compared to other group methods such as face to face interaction and found to be extremely accurate and reliable (Helmer 1967; Dalkey 1969; Brown, Cochran and Dalkey 1969; and Lindeman 1975). This can be attributed to the key components that eliminate the effects of group conformity, undue influence by dominant individuals and bias, which psychologists have proven in numerous studies to be problematic in face to face interactions (Dalkey 1969).

Another critical element of the Delphi technique is the selection of the expert respondents. A representative sample of the profession or organization should be selected, the members should be viewed as experts in their field and have the power to implement changes warranted by the

outcomes of the study concerned (Delbecq et al. 1975 and Fink et al. 1984). Expert members are deemed to be familiar with the problem, knowledgeable of current research in the area and aware of past trends that may have a bearing on the future (Duffield 1989). Homogenous or heterogenous group of individuals have both been used as expert panelists. However, it has been argued that in order to prevent a false consensus from being reached from individuals possessing similar inbred opinions, heterogenous groups should be used because of the varying perspectives they bring as a result of their diverse backgrounds (Starkweather, Gelwicks, and Newcomer 1975). Therefore, the reliability of the results may be weakened if the expert members are not carefully selected. The size of the group and the number of iterations employed are important as increases to both improve the reliability of the results (Dalkey 1969 and Fink et al. 1984).

The reliability of the Delphi technique was assessed in a study conducted to validate group consensus of one panel of homogenous experts. The competencies expected of first line nurse managers identified by a panel of registered nurses were compared with a second panel of registered nurses. The results were strikingly similar with consensus occurring for 156 out of the 168 competencies noted. The researcher cautions that although the results indicate the Delphi technique is reliable, the results may also be attributed to a lack of disagreement on this matter and further research is warranted (Duffield 1993).

In summary, the Delphi technique has numerous advantages if the procedures are carefully adhered to throughout the study. By obtaining a consensus from a group of experts, the information is deemed valid and reliably based. Concerning predictive studies, individuals who have a stake in the results are made part of the planning process. Intimidation and peer pressure are removed along with the problems of group dysfunction (Duffield 1989).

A proven method, the Delphi technique has been used extensively in the health care field. It has been used to formulate health care policy and research in Wisconsin (Gustafson et al. 1975), determine health priorities (Moscovice et al. 1977), and predict future trends in health care delivery and financing (Starkweather, Gelwicks, and Newcomer 1975). In the field of nursing, the Delphi technique has been used to determine clinical research priorities (Griffin et al. 1992 and Lindeman 1975), plan curriculums based on a forecast of nursing roles and practices (Sullivan and Brye 1983), and define nursing centers (Riesch, Fehring, and Schulte 1987). The Delphi technique has been used extensively to predict the key issues and SKAs required of health care administrators and leaders of MTFs through the year 2000 (Hudak et al. 1992 and Hudak, Brook, and Finstuen 1994).

As the focus of my study is similar to these two Delphi studies, the basic format and procedures to be followed were emulated. The intent of this study was to include members of the Executive Steering Committees from the 27 CONUS, Navy MTFs in this study. Specifically, Commanding Officers (COs), Executive Officers (XOs), Directors for Administration (DFAs), Directors for Nursing Services (DNSs) and Directors, Medical Services (DMSs) were queried to achieve a broad representation from each corps. As recognized leaders in military health care coupled with their first hand knowledge of the administrative challenges their organizations presently face in implementing the TRICARE contracts, they are the current experts in this field. Therefore, no other heterogeneous group was better suited to determine the current and future job functions and SKAs required of health care professionals serving in an administrative managed care capacity.

### Round One

In the first iteration, the expert respondents were asked to complete an open ended questionnaire by listing the top five job tasks to be performed by medical department officers serving in an administrative managed care position during the post contract award phase of the TRICARE managed care support contracts. For each task identified, members were also asked to state the key SKAs required to successfully perform them. The questionnaires were mailed to the Commanding Officers of each MTF requesting their assistance in ensuring the participation of other key members of their Executive Steering Committee. A detailed cover letter explaining the purpose of the study along with an endorsement from the Bureau of Medicine and Surgery was also enclosed to increase the response rates. The endorsement letter signed by the Assistant Chief of Health Care Operations, the cover letter to the Commanding Officers, information sheet, and questionnaire are provided in appendix (1). The 27 packages were mailed first class and each member was provided with a stamped self-addressed envelope to expedite receipt of the individual questionnaires. Individual follow-up letters were mailed to all participants and a copy of the letter is also provided in appendix (1). Follow-up telephone calls were then made to each command. As a result, a voluminous amount of data was received. Upon receipt, the data were entered into a data base, and any duplicate responses by individual respondents were highlighted and not factored into the final results. The working vocabulary of the data presented was then preserved through the assignment of key phrases.

Like key phrases were then grouped under reasonable job headings for presentation to individual members of the expert panel comprised of five senior Navy health care leaders. Each member of the panel made his or her recommended changes to the placement of key phrases

within the specific job headings, to the number of job headings themselves, and to the titles for each job heading. It was anticipated that several key phrases would be applicable to more than one category, but the members were asked to place each key phrase into only one mutually exclusive category. The requested changes were summarized and presented to the panel in a group meeting. The expert panel discussed collectively all of the individual recommendations and agreed upon additional modifications to arrive at a final consensus. The expert panel was selected based on recommendations received from key individuals at the Bureau of Medicine and Surgery. The categories were then ranked ordered based on the frequency of like responses received, and the SKAs identified for the key phrases were grouped under the appropriate key job category. It should be noted that ranking by frequencies is a method to display the data, and individual ranking assignments should not distract from the overall importance of the nine job categories identified from the data received from the Executive Steering Committees.

### Round Two

During the second iteration, the results of the panel were disseminated to all members previously identified in the first iteration regardless of round one participation. Individual packages were mailed first class to all 135 participants. The cover letter including the feedback from Round One and the two-part questionnaire are provided in appendix (2). Part one of the questionnaire requested that the participants provide demographic information and answer the following two questions: 1) Should a formal managed care department with dedicated billets be established at your facility? 2) If yes, where should it be placed on the organizational chart? The second part of the questionnaire consisted of the SKAs identified for each job category. The

members were asked to rate each of the 185 SKAs on a seven point relative importance rating scale, 1- extremely unimportant to 7 - extremely important, to determine their degree of relevancy to successful job performance. A follow up letter similar to the one provided in appendix (1) was mailed approximately ten days following the initial mail-out to increase the respond rate.

Descriptive statistics were computed using the SPSS statistical software for the ratings assigned to the various SKAs. Cronbach's Coefficient Alpha was used to assess the degree of inter-rater reliability of the ratings assigned to the various SKAs (Cooper and Emory 1995).

Additionally, to test the relationship between the responses received from the different groups of respondents, a simple linear regression analysis {Student's T-Test} was employed using a level of significance of .05 (Sanders 1995). Initially classifying the group as heterogenous based on their diverse education and background, this method was another measure to assess the reliability of the data. The hypotheses were: 1) the responses received for the SKAs by domain would be dissimilar between the Directors, Nursing Services and the Directors for Administration 2) the responses received for the SKAs by domain would be dissimilar between the Directors, Medical Services and the Directors for Administration. As this study dealt with health care administration issues, the Directors for Administration were selected as the independent variable because of their background as MSC officers and formal schooling in administration. Commanding Officers and Executive Officers were excluded from this analysis because all corps are represented in these positions.

### Ethical and Cost Concerns

The foundation of the Delphi technique centers on anonymous responses, which must be preserved. Participants were notified in the cover letter of the intended purpose of the research, the potential benefits to be realized, and their right to confidentiality. At no time were participants names or addresses, if received, divulged. The anonymity of the members comprising the expert panel was also protected. Willingness to participate in this study signified voluntary consent. At the completion of the study, all mail responses received were destroyed (Cooper and Emory 1995).

The monetary costs involved in mailing the two questionnaires and receiving them back were minimal. The greatest cost involved the time required of the participants to complete this study. It was anticipated that it would take at least one to one and one-half hours for every participant to complete both questionnaires, which was explained up front. Understanding the value of the participants' time, the questionnaires provided were as clear and unambiguous as possible to help streamline the process and ensure the success of the study. Prior to release, the questionnaires were reviewed by several individuals, and modified to ensure clarity and ease in understanding.



## **CHAPTER THREE**

### **RESULTS**

#### Round One

A 51 percent respond rate was achieved with 69 out of a total of 135 participants responding to the open-ended questionnaire. With the current downsizing of Military Medicine and transition to managed care, a few commands have restructured their organizations, which resulted in changes to titles and or positions to the current Executive Steering Committees. The effect this had on the response rate, if any, is considered minimal and inconsequential to this study. Additionally, the response rate experienced in this first round was acceptable for the type of methodology used in this study (Richie, Tagliareni, and Schmitt 1979).

The Executive Steering Committees identified 225 unique job tasks along with over a 1,000 SKAs. The expert panel following the methods and procedures previously described reached a group consensus resulting in nine key job categories being identified. The nine job categories in descending order based on frequency of like responses are: 1) Leadership, 2) Business Practices, 3) Marketing, 4) Management of Information, 5) Contract Administration, 6) Utilization Management/Quality Management, 7) Health care Delivery, 8) Cost and Finance, and 9) Contract Acquisition. These nine categories along with the number of unique tasks identified, frequency of responses, the number of SKAs to be rated and the list of key phrases grouped

under specific job categories are provided as part of appendix (2). Figure 1 highlights the number and type of responses received in Round One by job category:

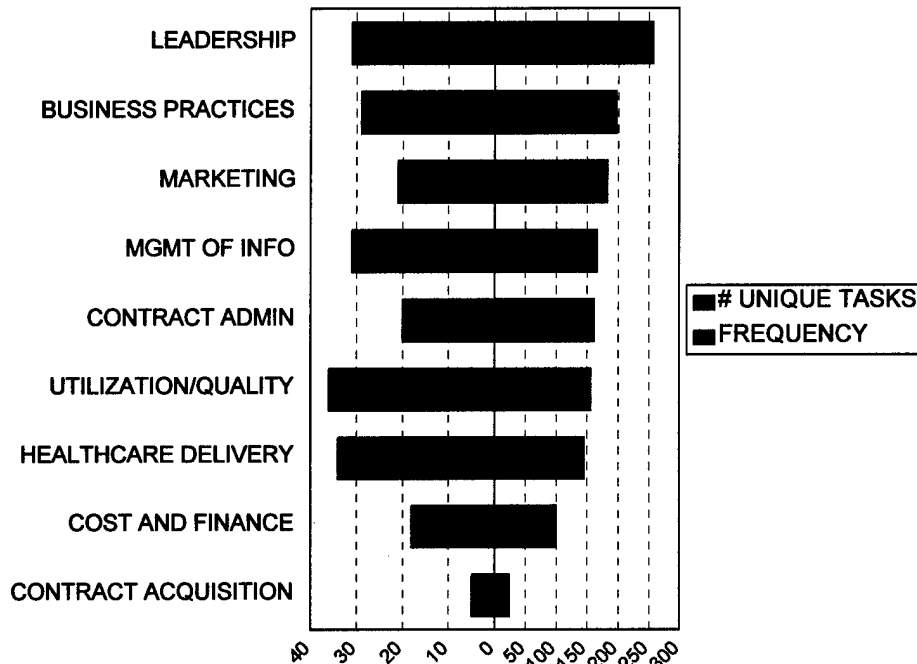


Fig. 1. Number of unique job tasks and frequency of like responses by job category.

The members of the expert panel consisted of four males and one female, average age of 47.4 years, with 121 years experience in health care and 44 years experience in managed care. Representing the medical service corps, nurse corps and medical corps, the members collectively hold three Masters Degrees, one Doctorate (Ph.D.), one Medical Degree (M.D.) and one degree in Jurisprudence (J.D.).

In order to validate the panel's selections, each panel member was asked to complete a seven point confidence rating scale to determine the degree of accuracy and confidence they have

placed in their individual assignments and revised group assignments. The scale ranged from 1 - extremely low confidence to 7 - extremely high confidence. The average rating for individual responses was 6.3 and the group rating was 7.0. A higher average rating on the final consensus of group assignments indicates a high degree of content validity (Cooper and Emory 1995; Milholland, Wheeler, and Heick 1973; and Dalkey, Brown, and Cochran 1969).

### Round Two

As in Round One, a total of 69 out of 135 possible participants yielded a 51 percent response rate, which is also considered acceptable. Representing teaching hospitals, medical clinics and Navy hospitals, the breakdown of the participants by position was as follows: DFAs - 15, COs - 15, XOs-14, DNSs - 14, and DMSs - 11. For those responding, the average age was 47.1 with 23.6 years experience in health care and 12.9 years experience in health care administration. Only three of the participants responding did not possess a Masters Degree or higher. Females comprised over 30 percent of the total number participating in this round. Ninety percent of the participants indicated that managed care department with dedicated billets should be established at their facilities. For those participants answering "yes," a wide variety of responses were received concerning where the managed care department should be placed on the organizational chart. The responses included making the department a part of the Directorate for Administration, a special assistant reporting to the Executive Officer or Commanding Officer or a separate directorate.

Missing data for eleven individual questions were replaced in SPSS by calculating the mean of the total responses for those questions. In all cases 2.8 percent or less of the data of the questions concerned were replaced using this method.

The results of the Cronbach Coefficient Alpha test to determine the overall inter-rater reliability among the entire group's responses (N=69) to the individual SKAs by job category is presented in table 3. A high degree of reliability or agreement was achieved with a range of .8996 for the SKAs contained in the Marketing Job Category to a high of .9576 for the SKAs contained in the Utilization Management/Quality Management Job Category.

**TABLE 3**  
**RELIABILITY OF SKAs RATINGS BY JOB CATEGORY**

Category	# SKAs Rated	SKAs Mean	Cronbach's Alpha
Leadership	26	5.6494	0.9219
Business Practices	25	5.3919	0.9435
Marketing	16	5.4369	0.8996
Management of Information	25	5.2890	0.9512
Contract Administration	18	5.5692	0.9114
Utilization Management/Quality Management	30	5.5755	0.9576
Healthcare Delivery	25	5.1872	0.9282
Cost and Finance	15	5.0493	0.9189
Contract Acquisition	5	4.8116	0.9247

The ratings on a 7 point scale for individual SKAs were further analyzed by comparing the average means for each SKA within their respective job category to arrive at the top rated SKA per job category and the lowest rated SKA per job category. Tables 4 and 5 contained in appendix (3), respectively, display these results along with the average means and standard deviations. The range of the means for the top rated SKAs by job category were from 5.2 (ability to analyze and evaluate contracts) to 6.7 (ability to effectively communicate with others).

Likewise, the highest rated SKAs overall, table 6, and the lowest rated SKAs, table 7, were analyzed and compared. Although many of the SKAs were duplicated between tables 4 and 6, and tables 5 and 7, a common theme emerged. The findings clearly showed that the Executive Steering Committees felt strongly that interpersonal skills were just as important as technical skills in many job categories if not more important overall for a successful job performance under the TRICARE program. Tables 6 and 7 are also contained in appendix (3).

In the final analysis to test the relationship between the responses received to the SKAs by key job categories, all but five out of a total of 18 comparisons were found to be statistically significant with a ( $p < .05$ ) signaling a high degree of like thinking between the DFAs and DNSs and DFAs and DMSs in these areas. The responses between DFAs and DMSs to the SKAs were found to be statistically nonsignificant ( $p > .05$ ) in the Marketing, Healthcare Delivery, Cost and Finance, and Contract Acquisition job categories. Only in the Contract Acquisition job category were the responses between the DFAs and DNSs found to be also statistically nonsignificant ( $p > .05$ ). The null hypotheses were therefore accepted in these five cases that the responses are dissimilar. Although considered a heterogeneous group, the results of the Cronbach Alpha to test overall inter-rater reliability coupled with the regression analysis indicated that the

Executive Steering Committees think in a homogenous fashion with some exceptions being noted between the DFAs and DNSs and DFAs and DMSs.

As the “r” factors for three of the five cases indicated, a weak correlation ( $r < .34$ ) existed between the DFAs and DMSs in their responses to the SKAs contained in the Marketing, Healthcare Delivery, and Cost and Finance job categories. Therefore, further research in this area may be warranted. The results by individual job categories are provided in table 8 of appendix (4) to include the degrees of freedom (df), coefficient of correlation ( r), t ratio, and level of significance.

## **CHAPTER FOUR**

### **DISCUSSION**

As the results indicate, nine key job functions with a myriad of related job tasks will be required to be performed by current and future medical department officers serving in administrative managed care positions throughout the post contract award phase of the TRICARE managed care support contracts. These job functions include new frontiers in military medicine such as marketing, managed care contract administration and acquisition. As reflected by the job tasks identified, the scope of other key job functions will be expanded under managed care from the need to conduct sound business practices to developing and managing provider networks as part of the health care delivery system. Furthermore, the overall findings appear highly consistent with the opinions expressed in the literature review by military and civilian health care executives concerning the key job functions and tasks to be performed in this new era of managed care.

Cost and finance will undoubtedly be an important job function; however, job tasks falling under the umbrella of Utilization Management and Quality Management will continue to take on a greater importance in this era of shrinking funds. Not only must a high standard of care be maintained, patient satisfaction must be measured in a new light to pinpoint the reasons why patients choose to return to the MTF. The recommended areas to measure include issues relating to access, communication, and administration (Fromberg 1997). Clinical processes to include

outcomes must also be managed and accurately measured according to the literature, which is indicative of the high frequency of responses associated with several of the job tasks under this category. These job tasks include analysis of the quality and efficiency of care, case management, and referrals to specialists.

Leadership is an established job prerequisite for all naval officers. This fact may help explain in part the high frequency of responses received from the Executive Steering Committees relating to the key phrases collapsed under the category of Leadership. However, based on military specific research previously discussed in the literature, leadership was ranked lower based on frequency of responses when compared to other major areas affecting health care executives. The researchers reflected that this may be attributed to the fact that the Army MTF leaders feel comfortable in this role. Therefore, it may not be considered as a prominent concern in relationship to other issues challenging military health care executives such as cost and finance, which was ranked number one (Hudak, Brooke, and Finstuen 1994). As this study was directed specifically at positions in managed care, the results may emphasize the heightened awareness by the Executive Steering Committees of the need for managed care administrators to be effective, people oriented leaders in this new age of health care delivery, which is supported in the literature review. Half of the top ten rated SKAs overall were grouped under the job category of Leadership lending further support to the relative significance of this category in the eyes of the Executive Steering Committees.

With the future of Military Medicine being challenged on a variety of fronts, the importance of the military's managed care program succeeding cannot be overemphasized. Therefore, the top tens SKAs overall are not surprising as they reflect many of the same key



SKAs cited in the literature numerous times to be essential prerequisites for future managed care executives to include the ability to adapt, communicate effectively, and work well with physicians.

These results may also reflect the growing concern at the MTFs of the need to strengthen customer relations. Pleasing the customer is a key component of managed care signaling the need for administrators in managed care positions to be customer service driven. No longer can Navy Medicine rightly assume that customer loyalty will sustain the willingness of the customers to continue to return to the MTFs for care, especially since, for a small fee they now have the choice of seeking primary care in the civilian community.

The ethics of managed care have been widely debated. As Navy Medicine prides itself on putting the patient first, this may account for the strong ratings by the respondents of the need for managed care administrators to possess strong ethics and have the courage to be able to stand up and fight for what they believe is the right thing to do.

Although the majority of respondents believe dedicated managed care billets should be established, caution is warranted. In individual meetings with two of the expert panel members, they both expressed concern that managed care is not just a job function for a few key individuals at the MTFs, but it is a system of care that must permeate the organizational culture.

The DMSs and DNSs at Navy MTFs appear to have a different perspective relating to the ratings of SKAs associated with four different job functions when compared to those of the DFAs. This may be attributed to their strong clinical background coupled with their experience in administration. This diversity of thought represents a strength of Navy Medicine especially if the prediction's by Coile and others comes true that the need for managed care executives with clinical backgrounds will be necessary in the future to successfully manage care. Furthermore,

Navy Medicine has successfully utilized this diversity in leadership by having any qualified officer serve as Executive Officers or Commanding Officers of MTFs. Therefore, it appears that a similar multi-diverse group of skilled individuals should also be considered for assignment to current and future administrative managed care positions at the MTFs. This strategy should be considered when developing future managed care billet structures and manpower allowances.

## **CHAPTER FIVE**

### **CONCLUSION**

This Navy-specific research has identified nine key job functions and the SKAs deemed critical for success while serving in an administrative managed care position throughout the post contract award phase of the TRICARE managed care support contracts. More important, the results are based on the responses received from leaders at the field activities lending credibility and support to the findings. However, as the TRICARE Program continues to evolve and new lessons are learned, it would be beneficial in future research efforts to seek similar opinions from the key staff members operating the civilian managed care support contracts.

The Bureau of Medicine and Surgery's Manpower Division can use these findings as an initial reference point to accurately assess the need to convert existing billets into managed care billets by specific ranks, corps, and subspecialties at the conus MTF level. Establishing a formal managed care department at each MTF will not be an easy task as Navy Medicine continues to feel the pressure of rightsizing. Although the majority of the members responding in this study support the need for managed care billets, it is important to keep in mind that active duty manpower allowances by subspecialty for peacetime support are driven by a valid readiness requirement. Therefore, this issue still needs to be adequately addressed using the Total Health

Care Support Readiness Requirements (THCSRR) model, which was developed to determine wartime and day to day operational requirements (Weber 1994).

The results provide a foundation for future service specific research to determine the level of education and experience required to perform successfully in a managed care position.

Although the managed care AQD code for the MSC has recently been established, modification or additional qualifiers may be warranted in the future. The current requirement of year experience may be inadequate to fully prepare individuals to fill certain positions. Research in regards to the need for "specialty training" in such areas as contract acquisition and administration may be indicated. This should not overshadow the need for administrators to have a broad knowledge base in all areas relating to managed care.

Individuals meeting the necessary prerequisites could then be easily identified and detailed appropriately. Any shortages identified could be overcome by the development of specific training plans, continuing education courses and targeted recruitment efforts. Additionally, those individuals contemplating a future assignment to a managed care position will now have a general understanding of the job functions and the type of skills necessary to perform well. The development of a self assessment tool would aid individuals to ascertain their strengths and weaknesses and develop a personal training plan to refine and hone their current skills and gain new ones.

Change is inevitable and this study reflects the opinions of Navy health care leaders who are in the midst of one of the largest transitions to occur in military medicine since the end of the Vietnam War. As both the military and civilian health care industries continue to adapt to ensure

survival under increased market pressures from payers, patients, and regulators, health care administrators can also thrive “as long as they remain as dynamic as the forces that guide them” (Carol 1997).

## **DELPHI STUDY MAIL-OUTS FOR ROUND ONE**

### **COMMANDING OFFICER'S COVER LETTER**

12013 Waterside View Drive  
Apt. #22  
Reston, VA 20192

02 December 1996

Commanding Officer  
Naval Hospital  
Box 788250, MCAGCC  
Twentynine Palms, CA 92278-8250

Dear:

I am currently completing the residency portion of my Masters Degree in Health Care Administration from the U.S. Army-Baylor University. I am conducting a research study entitled "Management of Managed Care: What Does It Take?"

The intent of this study is to identify the key administrative job functions to be performed throughout the post contract award phase at the local MTFs; as well as the skills, knowledge and abilities required of medical department officers to successfully complete them. The results will be disseminated to key departments at the Bureau of Medicine and Surgery to serve as a baseline for future policy decisions regarding managed care billets structure, placement, and educational and training needs.

You and the key members of your Executive Steering Committee have been chosen to participate in this important study. As recognized leaders in military health care coupled with your first hand knowledge of the challenges that your organizations are currently facing in implementing the TRICARE managed care support contracts, your expert opinions on this subject are highly valued.

Please take a moment to review the enclosed packet, which fully describes the study and contains the questionnaire. I am requesting your assistance in disseminating the information sheet and questionnaire to the following members of your staff: Executive Officer; Director for Administration; Director, Nursing Services; and Director, Medical Services. Additional copies with prepaid self-addressed envelopes have been provided.

**Appendix (1)**

I greatly appreciate your assistance and thank you for your participation in this important study. If you have any questions, please feel free to contact me at (703) 295-6692 or E-mail 71134.177@compuserve.com.

Very respectfully,

A. M. BRIGHT  
Lieutenant, Medical Service Corps  
United States Navy

**INFORMATION SHEET**  
**DELPHI STUDY**  
**"Management of Managed Care: What Does It Take?"**

**Background and Goals:** New job functions and tasks relating to managed care are emerging in conjunction with the life cycle of the TRICARE managed care support contracts. However, at the local Navy Medical Treatment Facilities (MTFs), formal consensus has not been reached, nor have the skills required of those serving in administrative managed care roles been clearly identified. The purpose of this study is two-fold:

- 1) to determine the key administrative job functions that will be necessary throughout the post-contract award period of the TRICARE managed care support contracts
- 2) to identify the skills, knowledge and abilities (SKAs) required of medical department officers to successfully perform these functions

**Expert Participants:** Commanding Officers, Executive Officers, Directors for Administration, Director, Nursing Services and Director, Medical Services of all CONUS, Navy MTFs have been selected to participate in this study. Representing all corps, you were chosen based on your demonstrated expertise, experience and first-hand knowledge of the administrative challenges facing your commands under TRICARE.

**Research Method:** The Delphi technique will be the research method used in this study. This technique developed at the Rand Corporation involves a series of iterations; whereby experts provide their individual opinions on a particular subject and through feedback and subsequent iterations, groups consensus is achieved. A proven method, it has been used extensively in the health care field to determine health care priorities, develop policy and predict future trends in health care delivery and financing.

Two iterations of the study will be conducted over a three month period. The first iteration requires you to complete the attached open-ended questionnaire, which will take approximately 30-45 minutes of your time. In the second iteration, you will be asked to complete a demographic profile and a second questionnaire by ranking on a 7 point scale the degree of importance you place on the specific SKAs identified in round one. Feedback from the first round and a summary of the final results will be disseminated to all designated participants and to key departments at the Bureau of Medicine and Surgery. Individual responses to the questionnaires will remain anonymous.

**Benefits:** The results of the study are important to Navy Medicine to help establish a formal consensus on the main administrative job functions to be performed throughout the post contract award phase of the TRICARE contracts at the local MTF level. The SKAs required of personnel to perform these functions at a high level will also be identified. More important, the results will have been determined by leaders at the field activities lending credence and support of the



findings. The results can serve as a baseline to assess the need to convert existing billets into managed care billets at the MTF level, and determine future education and training needs to fully prepare health care professionals to perform in this new era of managed care.

**Point of Contact:** This study is being conducted by Lieutenant Anne M. Bright, MSC, USN, a graduate student in health care administration at U.S. Army-Baylor University. She may be reached at (703) 295-6692 or E-Mail 71134.177@compuserve.com.



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
2300 E STREET NW  
WASHINGTON DC 20372-5300

IN REPLY REFER TO

6000  
Ser 32/0167  
4 Dec 96

From: Assistant Chief for Health Care Operations  
To: All Delphi Study Participants

Subj: DELPHI STUDY ENTITLED "MANAGEMENT OF MANAGED CARE:  
WHAT DOES IT TAKE?"

1. Lieutenant Anne Bright, MSC, USN, is a graduate student in Health Care Administration at the U.S. Army-Baylor program. She is conducting a study to help Navy Medicine determine the key administrative job functions that must be performed in order for the MTF to be successful in the post-TRICARE contract award managed care environment. The study will also help determine the skills, knowledge and abilities that medical department officers must possess in order to successfully perform those functions.

2. This study is coming at an opportune time for Navy Medicine. Almost every MTF has developed a unique organizational solution for implementing managed care. However, that solution is not supported by a billet structure or training plan. This study has the potential to help guide us as we move forward in establishing billets that detailers can use and in formulating plans to train officers to meet the managed care challenges.

3. I urge each one of you to help by taking the time to thoughtfully complete the enclosed questionnaire. Thank you for your support.

A handwritten signature in black ink, appearing to read "R. H. Brant", is positioned above the typed name.

R. H. BRANT  
Assistant Chief for  
Health Care Operations

## **ROUND ONE QUESTIONNAIRE**

Please complete the attached questionnaire and return it in the mail by 8 January 1997 using the enclosed pre-paid self-addressed envelopes.

Instructions: Please identify what you consider to be the top five job tasks to be performed by medical department officers serving in an administrative managed care position throughout the post-contract award phase of the TRICARE contracts. Two examples of possible job tasks include management of resource sharing agreements and development of marketing initiatives to increase beneficiary enrollment in TRICARE Prime.

For each task identified, please provide the skills, knowledge and abilities you believe are necessary for medical department officers to possess to successfully complete them. Concerning management of resource sharing agreements, the skills, knowledge and abilities may include strong negotiating skills, ability to communicate well with others, knowledge of contract law and understanding of bid-price adjustment. Please be as specific and detailed as possible in your responses.

### “Management of Managed Care: What Does It Take”

<u>JOB TASKS</u>	<u>SKILLS, KNOWLEDGE AND ABILITIES</u>
1)	a) b) c) d) e)
2)	a) b) c) d) e)
3)	a) b) c) d) e)
4)	a) b) c) d) e)
5)	a) b) c) d) e)

Additional Comments Are Welcomed:

Once again, I thank you for taking the time to participate in this important study.

## **FOLLOW-UP LETTER**

12013 Waterside View Drive  
Apt. 22  
Reston, VA 20194

18 December 1996

Executive Officer  
Naval Hospital  
One Pinckney Blvd.  
Beaufort, SC 29918-6148

Dear:

A packet containing the Delphi study entitled "Management of Managed Care: What Does It Take" was mailed to your Commanding Officer for distribution to you approximately two weeks ago. I hope you have received the packet and have agreed to participate in this important study. Your support and timely completion of the questionnaire are greatly appreciated.

If you haven't already completed the questionnaire, please take the time now and return it in the mail by 8 January 1997 using the stamped self-addressed envelope provided. Your personal input is critical to the success of this study. Every completed questionnaire will help ensure the findings are truly representative from all corps and CONUS, Navy Medical Treatment Facilities.

Once again, thank you for your time and assistance. If you have any questions, please feel free to contact me at (703) 295-6692 or E-mail 71134.177@compuserve.com.

Very respectfully,

A. M. BRIGHT  
Lieutenant, Medical Service Corps  
United States Navy

## **DELPHI STUDY MAIL-OUTS FOR ROUND TWO**

### **ROUND TWO COVER LETTER**

12013 Waterside View Drive  
Apt. 22  
Reston, VA 21094

24 Feb 1997

Director for Administration  
Naval Hospital  
One Pinckney Blvd.  
Beaufort, SC 29902-6148

Dear:

I want to personally thank everyone who participated in round one of the Delphi Study entitled, "Management of Managed Care: What Does It Take?" An excellent response rate of 51 percent was achieved with 69 out of a total number 135 participants responding to the questionnaire.

To briefly reiterate, the intent of this study is to identify the key administrative job functions to be performed throughout the post contract award period of the TRICARE managed care support contracts along with the skills, knowledge and abilities (SKAs) required of medical department officers to successfully complete them. Additionally, the results of this study can serve as a baseline to assess the need to convert existing billets into managed care billets at the local Military Treatment Facilities (MTFs), and determine future education and training needs.

An expert panel of five senior Navy health care leaders determined the placement of unique issues under specific job categories and the titles of each of the key job categories based on the data collected in round one. The data was collected from CONUS, Navy MTFs' Executive Officers; Executive Officers; Directors for Administration; Directors, Nursing Services; and Directors, Medical Services. The table contained on the next page highlights the results of round one.

The key job categories are ranked in descending order based on the total frequency of responses. More detailed feedback that provides a listing of the unique issues identified by job category along with the frequency of responses for each issue is provided as an addendum to this letter. Please take a moment to review this feedback.

**Appendix (2)**

Enclosed is the second and final questionnaire that asks you to provide some basic demographic information and rate the SKAs based on their relative importance to their associated job category. Please take the time to complete the questionnaire, whether you participated or not in the first round. Even though this questionnaire appears lengthy, you should find it much easier and less time consuming to complete than the first questionnaire. Prepaid self addressed envelopes have been provided for your use. Your timely completion of this questionnaire within seven working days of receipt is greatly appreciated.

### GENERAL FEEDBACK FROM ROUND ONE

KEY JOB CATEGORIES	# ISSUES IDENTIFIED	FREQUENCY OF RESPONSES	# SKAs TO BE RATED
Leadership	31	257	26
Business Practices	29	197	25
Marketing	21	183	16
Management of Information	31	166	25
Contract Administration	20	161	18
Utilization Management/Quality Management	36	156	30
Healthcare Delivery	34	146	25
Cost and Finance	18	100	15
Contract Acquisition	5	24	5
<b>Totals</b>	<b>225</b>	<b>1390</b>	<b>185</b>

In summary:

Sample Size	135
Total Responding	69
Percent Responding	51
Total Job Categories	9
Total Unique Issues Identified	225
Total Frequency of Issues	1390
Total SKAs to be Rated	185

Once again, thank you for taking the time to help establish a consensus on the key administrative job functions and the necessary SKAs. a summary of the final results will be provided to you by mail in the near future.

If you have any questions, please contact me at (703) 295-6692 or E-mail  
71134.177@compuserve.com.

Very respectfully,

A. M. BRIGHT  
Lieutenant, Medical Service Corps  
United States Navy



## **Feedback from Round One**

### **1) Leadership**

Total Issues Identified 31	45 Communicator
Total Frequency of Issues 257	23 Personality Traits (adaptable, courageous, tactful, etc.)
	22 General Manager/Administrator
	21 Team Building/Collaboration
	20 Leader
	14 Educator
	10 Liaison/Interface
	10 Innovative Thinker
	9 Human Resources Management
	9 Mentor and Motivator
	8 People Oriented
	8 Change Agent
	8 Principles/Values
	7 Staffing
	7 Visionary
	5 Partnering with Contractors
	4 Listener
	4 Civilian Personnel Issues
	4 Decision Maker
	3 Labor Management
	2 Efficiency Review
	2 Facilitator
	2 Organizational Design
	2 Networking
	2 Understand and Resolve Ethical Issues
	1 Role Model
	1 EEO
	1 Community Relations
	1 Competitive Behavior
	1 Practice Good Military Medicine
	1 Public and Private Lifestyle

### **2) Business Practices**

Total Issues Identified 29	26 Resource Sharing/Resource Support Agreements
Total Frequency of Issues 197	25 MTF and Community Capabilities and Performance
	18 Business Plan Development
	16 Strategic Planning/Management
	15 Dual Missions/Culture
	13 Business Practices/Politics

- 12 Memorandums of Understanding/Agreements
- 11 Trends in Healthcare Delivery/Healthcare Environment
  - 8 Cost/Benefit Analysis
  - 7 Workload Management
  - 7 Performance/Process Improvement
  - 6 Reengineering
  - 5 Advanced Degree (MBA/MPH)
  - 5 Statutes/Laws/Regulations
  - 3 Healthcare Planning
  - 3 Make vs. Buy
  - 2 Product Line Development
  - 2 Policy Development
  - 2 Manage Beneficiaries
  - 2 Participate in Healthcare Associations and Networks
  - 1 Technology Assessment
  - 1 Alternative Healthcare
  - 1 Executive Buy In
  - 1 GME Effects
  - 1 Economic Projector
  - 1 Learn from failures and successes
  - 1 Organizational dynamics
  - 1 Acquisition of Commercial Products
  - 1 Discounts for Care

### 3) Marketing

Total Issues Identified 21

Total Frequency of Issues 183

- 34 Marketing/Marketing Principles
- 22 Educate staff, patients and community on services, benefits & mcare
- 19 Prepare and Deliver Oral and Written Briefs
- 18 Know population and geography demographics
- 16 Know Needs of Patient Population
- 14 Develop Marketing Techniques (Advertising)
- 10 Marketing Strategies/Initiatives
  - 8 Salesmanship
  - 6 Market TRICARE Program
  - 6 Listen and Communicate to Customers
  - 5 Marketing Plan
  - 5 Public Relations
  - 5 Evaluate Marketing Effectiveness
  - 5 Public Affairs Officer
  - 3 Market Analysis
  - 2 Familiarity with Multimedia Presentation Equipment and Materials
  - 1 Market Health Promotion
  - 1 Ensure information received from contractor is correct

- 1 Share Ideas
- 1 Take Up Slack Where Contractor Leaves Off
- 1 Resources to Run Marketing Campaign

#### **4) Management of Information**

Total Issues Identified 31

Total Frequency of Issues 166

- 20 Information Systems: Hardware and Software (CHCS, EIS, CEIS, etc.)
- 18 Statistics
- 15 Computer Literate
- 14 Data and Report Analysis
- 11 Collection of Data
- 11 Analytical
- 9 Information Management
- 9 Computer Networking (E-mail, World Wide Web, etc.)
- 6 Computer Graphics/Spreadsheets
- 6 Presentation of Data
- 6 Interpretation of Data
- 5 Information Technology
- 5 Identify and Apply Metrics
- 4 Decision Making Based on Data
- 3 Medical Data Systems
- 3 Trend Analysis
- 3 Know Data Needs
- 2 Telemedicine/Telecommunication
- 2 Tracking Systems
- 2 Provider Interface
- 2 Quantitative Methods
- 1 Management Information Plan
- 1 Information Security Processes
- 1 Fiscal Management Systems
- 1 Equipment Operation
- 1 System Compatibility
- 1 Develop Meaningful Information Vehicles
- 1 Technical Reporting
- 1 Know Data Sources
- 1 Conceptualize
- 1 Sampling Methods

#### **5) Contract Administration**

Total Issues Identified 20

Total Frequency of Issues 161

- 31 Managed Care/TRICARE Contracts
- 30 Contract Negotiations
- 18 Managed Care/Managed Care Principles
- 15 TRICARE Plans/Policies and Rules

- 13 Contract Law
- 9 Contract Administration/Management
- 8 Monitor/Oversight of Contracts
- 6 Contractor's Role and Goals
- 6 Conflict Resolution Management
- 5 Contracting Officer's Technical Representative (COTR)
- 4 CHAMPUS Rules
- 3 Find "win-win" answers
- 3 Relationships with Lead Agent and BUMED
- 3 Creative Bargaining
- 2 Enforce Contracts
- 1 Contract Models
- 1 Civilian Practices
- 1 Commitment to Make TRICARE Work
- 1 Contract Modification Process
- 1 Exact Punitive measures

## **6) Utilization Management/Quality Management**

Total Issues Identified 36

Total Frequency of Issues 156

- 21 Utilization Management
- 13 Clinical Practice Guidelines
- 12 Case Management
- 11 Customer Service
- 10 Patient Relations
- 9 Monitor Referral to Specialists
- 9 Quality & Efficiency of Care - Assess and Analyze
- 8 Monitor Productivity/Performance
- 6 Quality Management/Performance Review
- 6 TQM/TQL
- 5 Risk Management
- 5 Patient and Staff Satisfaction (Monitor and Evaluate)
- 4 Control/Manage Utilization
- 4 Clinical Outcomes Management
- 3 Practice Patterns
- 3 Provider Profiling
- 3 Accreditation/JCAHO
- 2 Authorization Systems
- 2 Physician Incentives
- 2 Standards of Care
- 2 Performance Criteria
- 2 Quality Control Methods
- 1 UM Regulations
- 1 Admission/Discharge Interviews
- 1 Disease Management

- 1 Algorithms
- 1 Discharge Planning
- 1 Peer Review
- 1 Telephone Triage
- 1 Benchmarking
- 1 Utilization Review
- 1 Horizontal Integration
- 1 Influence Positive Outcomes from Processes
- 1 Decisions are patient directed
- 1 Report Cards
- 1 Problem Identification and Solution

## **7) Health care Delivery**

Total Issues Identified 34

Total Frequency of Issues 146

- 15 Network Development/Management
- 14 Knowledge of Medicine/Clinical Background
- 12 Primary Care Management
- 11 Enrollments
- 9 Wellness/Prevention Programs
- 9 Access to Care
- 8 Professional Relationships
- 7 Practicing Physician
- 7 Health Benefits Advising
- 5 Health Promotion
- 5 Credentialing
- 5 Appointment/Phone systems
- 4 Build Infrastructure
- 4 Patient Transportation Management
- 3 Implementation Plan
- 3 Manage Care in Catchment Area
- 3 Clinic Management and Staffing
- 2 Community health
- 2 Nurse Advice Line
- 2 Medical Staff Management
- 2 Patient Administration
- 2 Provider to Beneficiary Ratios
- 1 Clinical Operations
- 1 Health Risk Assessment
- 1 Medical Committee Functions
- 1 Dietetics
- 1 Exercise Physiology
- 1 Investment into Lifelong Needs of Patients
- 1 Nontraditional Health Care
- 1 Managed Health Care

- 1 Self Care Techniques
- 1 Central Transcribing Management
- 1 Medical Records Management
- 1 New Methods of Delivering Healthcare

## **8) Cost and Finance**

Total Issues Identified 18  
Total Frequency of Issues 100

- 26 Financial Management
- 18 Bid-Price Adjustment
- 12 Resource Management/Assessment
- 6 Accounting
- 6 Budgeting
- 5 Compensation/Reimbursement
- 4 Revised/Alternative Financing
- 3 Technology
- 3 Fiscal Regulations
- 3 Forecasting
- 3 Economics
- 3 Claims Processing
- 2 Fiscal Capitation
- 2 Cost Proposals
- 1 Resource Driven Model
- 1 Working Knowledge of DRGs, CPT and other terminology
- 1 Rating and Underwriting
- 1 Economic Impact of Enrollment Fees

## **9) Contract Acquisition**

Total Issues Identified 5  
Total Frequency of Issues 24

- 14 Contracting/Solicitation
- 4 Contract Analysis/Evaluation
- 3 Federal Acquisition Regulations
- 2 Contract Specifications Writing
- 1 SSEB Process

## ROUND TWO QUESTIONNAIRE

### PART ONE: DEMOGRAPHIC PROFILE

Please take a few moments to answer the following by either filling in the blank or placing an "X" in the appropriate spot.

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#### Personal Data

**Position:** DFA\_\_\_\_\_ DNS\_\_\_\_\_ DMS\_\_\_\_\_ XO\_\_\_\_\_ CO\_\_\_\_\_

**Pay Grade:** 03\_\_\_\_\_ 04\_\_\_\_\_ 05\_\_\_\_\_ 06\_\_\_\_\_ 07\_\_\_\_\_ 08\_\_\_\_\_

**Gender:** Male\_\_\_\_\_ Female\_\_\_\_\_ **Age:**\_\_\_\_\_

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#### Organizational Type

Teaching Hospital\_\_\_\_\_ Naval Hospital\_\_\_\_\_ Medical Clinic\_\_\_\_\_

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#### Education and Experience

Please mark all those apply:

Bachelors Degree\_\_\_\_\_ Masters Degree\_\_\_\_\_ Ph.D.\_\_\_\_\_ M.D.\_\_\_\_\_

Other (Please specify)\_\_\_\_\_

Years experience in health care\_\_\_\_\_ Years experience in health care administration\_\_\_\_\_

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#### Professional Affiliation

Please provide the name(s) of the professional organizations of which you are current member (i.e. ACHE, AMA, etc.):

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#### Questions Relating to the Managed Care Positions Within Your Facility

1. Should a formal managed care department with dedicated billets be established at your facility?

YES\_\_\_\_\_ NO\_\_\_\_\_

2. If yes, where should it be placed on the organizational chart?\_\_\_\_\_

## ROUND TWO QUESTIONNAIRE

### PART TWO: RATING OF THE SKILLS, KNOWLEDGE AND ABILITIES

Please take a moment to rate the skills, knowledge and abilities based on the responses received in round one of the Delphi study by rating them on a scale of 1 to 7 on their relative importance.

1 = extremely unimportant 7 = extremely important Please circle your answers.

#### JOB CATEGORY: LEADERSHIP

(Extremely Unimportant to  
Extremely Important)

- |     |  |   |   |   |   |   |   |   |
|-----|--|---|---|---|---|---|---|---|
| 1)  | Ability to effectively communicate with others<br>(internal/external to organization)  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2)  | Courage to face adversity and a willingness to take a<br>stand for what is right   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3)  | Ability to adapt to a changing environment   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4)  | General Management and Administrative Skills   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5)  | Skilled at developing highly cohesive teams  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6)  | Ability to facilitate collaborate efforts between Tri-service<br>Medical Departments, Lead Agents and the<br>local civilian community          | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7)  | Ability to effectively lead others by employing the<br>the appropriate leadership style and strategies<br>to encourage desired staff responses | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8)  | Excellent training skills  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9)  | Ability to serve as a liaison between medical staff,<br>MTF, and contractors   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10) | Innovative Thinker and Visionary   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11) | Background in Human Resources Management   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |



12)	Skilled as a mentor and able to develop the potential in others	1	2	3	4	5	6	7
13)	People Oriented Skills	1	2	3	4	5	6	7
14)	Change Agent	1	2	3	4	5	6	7
15)	Possesses strong core personal values and principles and is able to incorporate them into personal and professional lifestyle	1	2	3	4	5	6	7
16)	Ability to acquire the right staff for the right job	1	2	3	4	5	6	7
17)	Ability to establish partnerships with contractors	1	2	3	4	5	6	7
18)	Ability to effectively listen to others	1	2	3	4	5	6	7
19)	Knowledge of Civilian Personnel Policies and Regulations	1	2	3	4	5	6	7
20)	Skilled Decision Maker	1	2	3	4	5	6	7
21)	Knowledge of Labor Management to include union relations	1	2	3	4	5	6	7
22)	Experience in developing staffing standards and conducting an Efficiency Review	1	2	3	4	5	6	7
23)	Skilled facilitator	1	2	3	4	5	6	7
24)	Knowledge of organizational design	1	2	3	4	5	6	7
25)	Skilled at networking	1	2	3	4	5	6	7
26)	Knowledge of the components of ethical decision making and is able to help resolve ethical dilemmas	1	2	3	4	5	6	7

## JOB CATEGORY: BUSINESS PRACTICES

(Extremely Unimportant to  
Extremely Important)

- |     |   |   |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|---|---|
| 1)  | Knowledge, understanding, and ability to manage resource sharing/resource support agreements          | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2)  | Knowledgeable in the capabilities of the MTF and local civilian medical community                     | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3)  | Ability to develop sound business plan  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4)  | Skilled in strategic planning   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5)  | Understands dual missions of the command (peacetime and operational) and culture of the MTF           | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6)  | Knowledge of business practices and political savvy   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7)  | Ability to develop Memorandums of Understanding   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8)  | Knowledge of current trends in health care delivery and the health care environment                   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9)  | Skilled at conducting cost/benefit analysis   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10) | Ability to account for workload and assign costs  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11) | Ability to identify areas for process improvement   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12) | Knowledge of reengineering processes  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13) | Possesses advanced degree in Health Care Administration or related discipline (M.B.A., M.P.H., etc.)  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14) | Knowledge of federal and state statutes, laws and regulations relating to the delivery of health care | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15) | Experience in health care planning  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

16)	Skilled at Make vs. Buy decision making	1	2	3	4	5	6	7
17)	Knowledge of Product Line Development	1	2	3	4	5	6	7
18)	Skilled at developing policies	1	2	3	4	5	6	7
19)	Knowledge of how to effectively manage beneficiaries, health care services and dollars	1	2	3	4	5	6	7
20)	Participate in Healthcare Associations and Networks with civilian counterparts	1	2	3	4	5	6	7
21)	Ability to conduct technology assessment	1	2	3	4	5	6	7
22)	Knowledge of Alternative Healthcare	1	2	3	4	5	6	7
23)	Skilled at gaining Executive Buy In	1	2	3	4	5	6	7
24)	Skilled Economic Projector	1	2	3	4	5	6	7
25)	Knowledge of organizational dynamics	1	2	3	4	5	6	7

### **JOB CATEGORY: MARKETING**

**(Extremely Unimportant to  
Extremely Important)**

1)	Knowledge of marketing principles	1	2	3	4	5	6	7
2)	Ability to educate staff, patients and the community on services, benefits and managed care	1	2	3	4	5	6	7
3)	Excellent presentation skills	1	2	3	4	5	6	7
4)	Knowledge of population and geography demographics	1	2	3	4	5	6	7
5)	Knowledge and understanding of patients' needs and wants	1	2	3	4	5	6	7
6)	Knowledge of various marketing techniques	1	2	3	4	5	6	7
7)	Ability to develop marketing strategies and initiatives	1	2	3	4	5	6	7
8)	Skilled as a salesman	1	2	3	4	5	6	7

9)	Ability to effectively market the TRICARE Program	1	2	3	4	5	6	7
10)	Ability to effectively listen and communicate with customers	1	2	3	4	5	6	7
11)	Ability to develop sound marketing plan	1	2	3	4	5	6	7
12)	Skilled at Public Relations	1	2	3	4	5	6	7
13)	Ability to evaluate the effectiveness of marketing efforts	1	2	3	4	5	6	7
14)	Experience as a Public Affairs Officer	1	2	3	4	5	6	7
15)	Knowledge of how to conduct a market analysis	1	2	3	4	5	6	7
16)	Knowledge of multimedia presentation equipment and materials	1	2	3	4	5	6	7

#### **JOB CATEGORY: MANAGEMENT OF INFORMATION**

**(Extremely Unimportant to  
Extremely Important)**

1)	Knowledge of various Information Systems, hardware and software to include MEPRS, EIS, CEIS, Managed Care Module of CHCS, etc.	1	2	3	4	5	6	7
2)	Strong background in statistics	1	2	3	4	5	6	7
3)	Computer literate	1	2	3	4	5	6	7
4)	Skilled as a data analyst	1	2	3	4	5	6	7
5)	Ability and skill to collect appropriate data	1	2	3	4	5	6	7
6)	Analytical ability	1	2	3	4	5	6	7
7)	Experience in Information Management	1	2	3	4	5	6	7
8)	Computer networking skills (E-Mail, World Wide Web, etc.)	1	2	3	4	5	6	7
9)	Ability to use computer graphics and spreadsheets	1	2	3	4	5	6	7

10)	Ability to present data in a meaningful way that others will understand	1	2	3	4	5	6	7
11)	Ability to interpret data	1	2	3	4	5	6	7
12)	Knowledge of Information Technology	1	2	3	4	5	6	7
13)	Ability to identify and apply metrics	1	2	3	4	5	6	7
14)	Ability to make decisions based on analysis of data	1	2	3	4	5	6	7
15)	Knowledge of current Medical Data Systems	1	2	3	4	5	6	7
16)	Ability to conduct trend analysis	1	2	3	4	5	6	7
17)	Knowledge of data requirements and data sources available	1	2	3	4	5	6	7
18)	Knowledgeable in Telemedicine/Telecommunication Systems	1	2	3	4	5	6	7
19)	Ability to implement tracking systems	1	2	3	4	5	6	7
20)	Knowledge of the importance of provider interface capabilities	1	2	3	4	5	6	7
21)	Skilled in Quantitative Methods	1	2	3	4	5	6	7
22)	Ability to develop Management Information Plan	1	2	3	4	5	6	7
23)	Knowledge of sampling methods	1	2	3	4	5	6	7
24)	Ability to conceptualize	1	2	3	4	5	6	7
25)	Knowledge of equipment operations and systems' compatibility	1	2	3	4	5	6	7

## JOB CATEGORY: CONTRACT ADMINISTRATION

		(Extremely Unimportant to Extremely Important)						
1)	Thorough knowledge and understanding of the Managed Care/TRICARE contracts	1	2	3	4	5	6	7
2)	Skilled in contract negotiations	1	2	3	4	5	6	7
3)	Thorough knowledge and understanding of managed care and the principles of managed care	1	2	3	4	5	6	7
4)	Knowledge of CHAMPUS rules and TRICARE Plans and Policies	1	2	3	4	5	6	7
5)	Knowledge and understanding of contract law	1	2	3	4	5	6	7
6)	Skilled in contract administration/management	1	2	3	4	5	6	7
7)	Ability to effectively oversee and monitor contractor's performance based on the provisions of the contract	1	2	3	4	5	6	7
8)	Understands contractor's role and goals	1	2	3	4	5	6	7
9)	Skilled in conflict resolution	1	2	3	4	5	6	7
10)	Experience as a Contracting Officer's Technical Representative (COTAR)	1	2	3	4	5	6	7
11)	Ability to find win-win answers	1	2	3	4	5	6	7
12)	Understand Lead Agent and BUMED relationships	1	2	3	4	5	6	7
13)	Knowledge of creative bargaining	1	2	3	4	5	6	7
14)	Ability to enforce contract specifications when required	1	2	3	4	5	6	7
15)	Knowledge of civilian managed care practices	1	2	3	4	5	6	7
16)	Commitment to make the TRICARE Program Work	1	2	3	4	5	6	7

- |     |  |   |   |   |   |   |   |   |
|-----|--|---|---|---|---|---|---|---|
| 17) | Knowledge of contract modification process | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18) | Knowledge of contract models               | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**JOB CATEGORY: UTILIZATION MANAGEMENT/QUALITY MANAGEMENT**

- |     |   | <b>(Extremely Unimportant to<br/>Extremely Important)</b> |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|---|---|
| 1)  | Knowledgeable in Utilization Management   | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 2)  | Knowledge of clinical practice guidelines   | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 3)  | Knowledge of Case Management  | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 4)  | Customer service oriented   | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 5)  | Skilled at patient relations with the ability to handle customers' complaints       | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 6)  | Ability to effectively monitor referrals to specialists and track referral patterns | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 7)  | Ability to assess and analyze quality and efficiency of care                        | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 8)  | Ability monitor and measure MTF's productivity and performance                      | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 9)  | Knowledge of Quality Management and Performance Review                              | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 10) | Knowledgeable in the principles of TQM/TQL  | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 11) | Knowledge of Risk Management  | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 12) | Ability to monitor and evaluate patient and staff satisfaction                      | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 13) | Knowledge of mechanisms to control and manage utilization                           | 1   | 2 | 3 | 4 | 5 | 6 | 7 |
| 14) | Knowledge of Clinical Outcomes Management   | 1   | 2 | 3 | 4 | 5 | 6 | 7 |

15)	Ability to identify practice patterns of providers	1	2	3	4	5	6	7
16)	Knowledge of provider profiling	1	2	3	4	5	6	7
17)	Knowledge with JCAHO and other accreditation processes	1	2	3	4	5	6	7
18)	Knowledge of Authorization systems	1	2	3	4	5	6	7
19)	Knowledge of physician incentive plans	1	2	3	4	5	6	7
20)	Knowledge of standards of care	1	2	3	4	5	6	7
21)	Ability to develop performance criteria	1	2	3	4	5	6	7
22)	Knowledge of quality control methods	1	2	3	4	5	6	7
23)	Knowledge of UM Regulations	1	2	3	4	5	6	7
24)	Knowledge of Disease Management	1	2	3	4	5	6	7
25)	Experience in using algorithms	1	2	3	4	5	6	7
26)	Knowledge of Discharge Planning	1	2	3	4	5	6	7
27)	Knowledge of Utilization Review	1	2	3	4	5	6	7
28)	Knowledge of report cards	1	2	3	4	5	6	7
29)	Ability to identify problems and arrive at solutions	1	2	3	4	5	6	7
30)	Knowledge of the benefits of horizontal integration (i.e. reduce duplication of services, share resources)	1	2	3	4	5	6	7

#### **JOB CATEGORY: HEALTHCARE DELIVERY**

**(Extremely Unimportant to  
Extremely Important)**

1)	Ability to develop and maintain a network of providers	1	2	3	4	5	6	7
2)	Knowledge of medicine/strong clinical background	1	2	3	4	5	6	7
3)	Experience in Primary Care Management	1	2	3	4	5	6	7



4)	Knowledgeable of enrollment process	1	2	3	4	5	6	7
5)	Ability to establish Wellness/Prevention Programs	1	2	3	4	5	6	7
6)	Knowledge and understanding of access to care issues and ability to monitor compliance with access standards	1	2	3	4	5	6	7
7)	Ability to establish creditability and sound working relationships with healthcare providers	1	2	3	4	5	6	7
8)	Experience as a practicing physician	1	2	3	4	5	6	7
9)	Knowledge of Health Benefits Advising	1	2	3	4	5	6	7
10)	Knowledge and commitment to Health Promotion	1	2	3	4	5	6	7
11)	Knowledge of credentialing and privileging	1	2	3	4	5	6	7
12)	Knowledge of MTF Appointment/Phone System	1	2	3	4	5	6	7
13)	Ability to build infrastructure to effectively deliver care to beneficiaries	1	2	3	4	5	6	7
14)	Knowledge of Patient Transportation Management	1	2	3	4	5	6	7
15)	Ability to develop an implementation plan to successfully transition to TRICARE	1	2	3	4	5	6	7
16)	Ability to manage care within the catchment area	1	2	3	4	5	6	7
17)	Experience in managing and staffing a clinic	1	2	3	4	5	6	7
18)	Knowledgeable in community health and public health assets	1	2	3	4	5	6	7
19)	Knowledge of Nurse Advice Lines	1	2	3	4	5	6	7
20)	Experience in Medical Staff Management	1	2	3	4	5	6	7
21)	Background in Patient Administration	1	2	3	4	5	6	7
22)	Ability to determine provider to beneficiary ratios	1	2	3	4	5	6	7

23)	Knowledge of clinical operations	1	2	3	4	5	6	7
24)	Knowledge of self care techniques	1	2	3	4	5	6	7
25)	Knowledge of Central Transcribing and Medical Records Management	1	2	3	4	5	6	7

### **JOB CATEGORY: COST AND FINANCE**

		<b>(Extremely Unimportant to Extremely Important)</b>						
1)	Background in Financial Management	1	2	3	4	5	6	7
2)	Knowledge and understanding of bid-price adjustment process	1	2	3	4	5	6	7
3)	Experience in Resource Management	1	2	3	4	5	6	7
4)	Accounting skills	1	2	3	4	5	6	7
5)	Budgeting skills	1	2	3	4	5	6	7
6)	Knowledge of compensation/reimbursement systems	1	2	3	4	5	6	7
7)	Knowledge of revised/alternative financing	1	2	3	4	5	6	7
8)	Ability to assess the costs of evolving technology	1	2	3	4	5	6	7
9)	Knowledge and understanding of fiscal regulations	1	2	3	4	5	6	7
10)	Knowledge of forecasting techniques	1	2	3	4	5	6	7
11)	Knowledge of economic issues	1	2	3	4	5	6	7
12)	Knowledge of claims processing	1	2	3	4	5	6	7
13)	Knowledge of fiscal capitation	1	2	3	4	5	6	7
14)	Ability to evaluate cost proposals	1	2	3	4	5	6	7
15)	Knowledge of DRGs, CPT codes and other terminology	1	2	3	4	5	6	7

## **JOB CATEGORY: CONTRACT ACQUISITION**

**(Extremely Unimportant to  
Extremely Important)**

1)	Knowledge and experience in Contracting/Solicitation Process	1	2	3	4	5	6	7
2)	Ability to analyze and evaluate contracts	1	2	3	4	5	6	7
3)	Knowledge of the Federal Acquisition Regulations	1	2	3	4	5	6	7
4)	Knowledge of the dynamics involved in the Source Selection Evaluation Board (SSEB) Process	1	2	3	4	5	6	7
5)	Skill in writing contract specifications	1	2	3	4	5	6	7

## SKAs ANALYSES

**TABLE 4**

### **DESCRIPTIVE STATISTICS FOR THE TOP RATED SKAs BY JOB CATEGORY**

<b>Category</b>	<b>SKAs</b>	<b>Mean</b>	<b>SD</b>
Leadership	Ability to effectively communicate with others (internal/external to organization)	6.7971	0.4051
Business Practices	Knowledgeable in the capabilities of the MTF and local civilian medical community	6.2174	0.8020
Marketing	Ability to effectively listen and communicate with customers	6.5507	0.6539
Management of Information	Ability to make decisions based on analysis of data	6.2464	0.7935
Contract Administration	Commitment to make the TRICARE Program Work	6.4928	0.7597
Utilization Management Quality Management	Customer Service Oriented	6.6522	0.6377
Healthcare Delivery	Ability to establish creditability and sound working relationships with healthcare providers	6.3768	0.8063
Cost and Finance	Ability to evaluate cost proposals	5.6377	1.0568
Contract Acquisition	Ability to analyze and evaluate contracts	5.2464	1.3548

Note: N=69

**Appendix (3)**

**TABLE 5**

**DESCRIPTIVE STATISTICS FOR THE  
LOWEST RATED SKAs FOR EACH JOB CATEGORY**

<b>Category</b>	<b>SKAs</b>	<b>Mean</b>	<b>SD</b>
Leadership	Experience in developing staffing standards and conducting an Efficiency Review	4.1449	1.2635
Business Practices	Ability to conduct a technology assessment	4.5362	1.1953
Marketing	Experience as a Public Affairs Officer	3.9275	1.3647
Management of Information	Strong background in statistics	4.3478	1.1610
Contract Administration	Experience as a Contracting officer's Technical Representative (COTAR)	4.0362	1.4761
Utilization Management Quality Management	Experience in using algorithms	4.5217	1.3351
Healthcare Delivery	Experience as a practicing physician	4.0580	2.0643
Cost and Finance	Accounting skills	4.1304	1.5040
Contract Acquisition	Skill in writing contract specifications	4.4493	1.6763

Note: N=69

**TABLE 6**  
**DESCRIPTIVE STATISTICS**  
**FOR THE TOP TEN RATED SKAs OVERALL**

<b>SKAs</b>	<b>Mean</b>	<b>SD</b>	<b>Category</b>
Ability to effectively communicate with others (internal/external to organization)	6.7971	0.4051	Leadership
Customer Service Oriented	6.6522	0.6377	Utilization Management Quality Management
Ability to adapt to a changing environment	6.5652	0.8485	Leadership
Ability to effectively listen and communicate with customers	6.5507	0.6539	Marketing
Commitment to make the TRICARE Program work	6.4928	0.7597	Contract Administration
Courage to face adversity and a willingness to take a stand for what is right	6.4493	0.8495	Leadership
Ability to effectively listen to others	6.4493	0.7384	Leadership
Ability to establish credibility and sound working relationships with healthcare providers	6.3768	0.8063	Healthcare Delivery
Ability to identify problems and arrive at solutions	6.3768	0.9564	Utilization Management Quality Management
Possesses strong core personal values and principles and is able to incorporate them into personal and professional lifestyle	6.3333	1.0098	Leadership

Note: N = 69

**TABLE 7**  
**DESCRIPTIVE STATISTICS**  
**FOR THE TEN LOWEST RATED SKAs OVERALL**

SKAs	Mean	SD	Category
Experience as a Public Affairs Officer	3.9275	3.9275	Marketing
Experience as a Contracting officer's Technical Representative (COTAR)	4.0362	1.4761	Contract Administration
Experience as a practicing physician	4.0580	2.0643	Healthcare Delivery
Accounting Skills	4.1304	1.5040	Cost and Finance
Experience in developing staffing standards and conducting an Efficiency Review	4.1449	1.2635	Leadership
Knowledge of Central Transcribing and Medical Records Management	4.1449	1.5173	Healthcare Delivery
Strong background in statistics	4.3478	1.1610	Management of Information
Background in Human Resources Management	4.4203	1.1299	Leadership
Skill in writing contract specifications	4.4493	1.6763	Contract Acquisition
Knowledge of multimedia presentation equipment and materials	4.4638	1.3348	Marketing
Knowledge of Patient Transportation Management	4.4638	1.2076	Healthcare Delivery

Notes: N = 69. Eleven SKAs are listed in table as a result of a tie.

**TABLE 8**  
**LINEAR REGRESSION ANALYSIS**  
**(Student's T-Test)**

<b>Category Group Comparisons</b>	<b>df</b>	<b>r</b>	<b>t ratio</b>	<b>Level of Significance (p&lt;.05)</b>
Leadership DNS to DFA	(1,25)	0.906	10.516	.000
DMS to DFA		0.827	7.203	.000
Business Practices DNS to DFA	(1,24)	0.722	5.022	.000
DMS to DFA		0.572	3.340	.003
Marketing DNS to DFA	(1,15)	0.925	9.112	.000
DMS to DFA		<u>0.331</u>	1.311	<b>.211</b>
MGMT of Information DNS to DFA		0.744	5.341	.000
DMS to DFA	(1,24)	0.676	4.398	.000
Contract Administration DNS to DFA	(1,14)	0.581	2.853	.012
DMS to DFA		0.492	2.260	.038
Utilization/Quality Mgmt DNS to DFA		0.760	6.195	.000
DMS to DFA	(1,29)	0.703	5.231	.000
Healthcare Delivery DNS to DFA	(1,24)	0.717	4.938	.000
DMS to DFA		<u>0.275</u>	1.373	<b>.183</b>
Cost and Finance DNS to DFA	(1,14)	0.758	17.571	.001
DMS to DFA		<u>-0.069</u>	-0.251	<b>.806</b>
Contract Acquisition DNS to DFA	(1,4)	0.548	1.135	<b>.339</b>
DMS to DFA		0.722	1.807	<b>.169</b>

**Appendix (4)**



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